tate not only the productivity of the practice, but the extent to which the physician must devote time or desires to be a manager or consultant for care rather than a direct provider of care.

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Managing Cardiac Tamponade

At Charity Hospital in New Orleans we have a trauma service that I think represents about 60 percent of all our surgical load. It's not unusual to see 10 or 11 instances of tamponade within a given month. When one sees a patient undergoing tamponade, don't try to make the diagnosis on a chest film. Almost invariably, in acute tamponade, you don't get the bottle-sized heart—that's chronic pericardial effusion. These patients often have a small heart. It may be an emergency film and it may not be adequate. You don't always see an elevated central venous pressure, particularly if the tamponade is severe enough so that cardiac output is impinged upon. In fact, the central venous pressure may even be zero at times. A high index of suspicion, really, is about the only thing you have to go on in a penetrating injury (gunshot wound or stab wound) usually in the region of the heart. If there's any question at all, don't hesitate to do a pericardiocentesis.

—THEODORE DRAPANAS, MD, *New Orleans*

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